

**CITY OF TOLEDO, OHIO
TRANSCRIPT OF A RECORD OF BIRTH**

**STATE OF OHIO
DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF BIRTH**

PLACE OF BIRTH
County of Lucas
Township of _____
or _____
Village of _____
or Toledo, O.
City of _____

Registration District No. 769 File No. _____
Primary Registration District No. 8349 Registered No. 5862
No. 158 Dexter St. St. _____ Ward _____
(If birth occurred in a hospital or institution, give name instead of street and number)

FULL NAME OF CHILD Florence Stasiak (If child is not yet named, make supplemental report, as directed)

Sex of Child Female Twin, triplet or other? _____ Number in order of birth _____ Legitimate? Yes Date of birth 12 17 17
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER FULL NAME Ignacy Stasiak MOTHER FULL MAIDEN NAME Martha Jankowski

RESIDENCE Including P. O. Address 158 Dexter St. RESIDENCE Including P. O. Address Same

COLOR or RACE White AGE AT LAST BIRTHDAY 45 (Years) COLOR or RACE White AGE AT LAST BIRTHDAY 35 (Years)

Birthplace (city or place) Austria (State or county) Birthplace (city or place) Germany (State or county)

OCCUPATION	a. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Iron Molder</u>	OCCUPATION	d. Trade, profession, or particular kind of work done, as housekeeper, typist, nurse, clerk, etc. <u>Housewife</u>
	b. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____		e. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. _____
	c. Date (month and year) last engaged in this work 19 _____		f. Date (month and year) last engaged in this work 19 _____
	g. Total time (years) spent in this work _____		h. Total time (years) spent in this work _____

Number of children of this mother (At time of this birth and including this child) 5 (a) Born alive and now living 5 (b) Born alive but now dead _____ (c) Stillborn _____

Is child congenitally deformed? _____ Was Prophylactic against Ophthalmia Neonatorum used? _____

If stillborn, period of gestation _____ months or weeks Cause of stillbirth _____ (Before labor) _____ (During labor) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 6:15A m. on the date above stated. (Born Alive or Stillborn)

(When there was no attending physician or midwife, then the father, householder, etc., should make this return.)
Given name added from a supplemental report _____

(Signed) F. J. Kallmerten M.D. M. D. Physician _____ Midwife _____

Address 2929 Lagrange St.

Filed 12 21 19 17 Sam F. Smith

Sam F. Smith

REGISTRAR

REGISTRAR

I hereby certify the above to be a true and correct transcript of a Certificate of Birth on file at the office of the Department of Health

Sam F. Smith
Registrar

7/15/41

Toledo, Ohio, _____ 19__

(SEAL)